
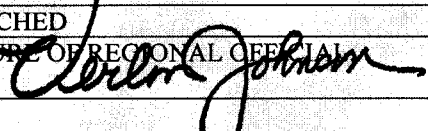


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED  
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 12-003	2. STATE Wisconsin
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE <del>01/01/2012</del> 4/1/2012	
5. TYPE OF PLAN MATERIAL (Check One):		
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)		
6. FEDERAL STATUTE/REGULATION CITATION: Section 1832 (a) (2) (F) of the Social Security Act and 42 USC Part 416	7. FEDERAL BUDGET IMPACT: a. FFY 2012 .....\$0K b. FFY 2013 .....\$0K	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-B, Page 4.d. ....	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Same	
10. SUBJECT OF AMENDMENT: Ambulatory surgical centers		
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		
12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Brett Davis State Medicaid Director 1 W. Wilson St. P.O. Box 309 Madison, WI 53701-0309	
13. TYPED NAME: Brett Davis		
14. TITLE: State Medicaid Director		
15. DATE SUBMITTED: 3/26/12 March 30, 2012		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED: March 30, 2012	18. DATE APPROVED: OCT 2 2012	
PLAN APPROVED - ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2012	20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Verlon Johnson	22. TITLE: Associate Regional Administrator	
23. REMARKS:		

RECEIVED  
APR - 9 2012  
DMCH - ARA